Case Presentation

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PERSONAL HISTORY

- 21 yrs old female patient
- House wife from KafrElsheikh
- widow for few months with 1offspring (2yrs old)
- No special habits of medical importance.

Her Story started few months after her husband death when She noticed progressive abdominal enlargement for which seeked medical advice at her village

Her Physician asked for The following INV

- HCV Ab:+ve
- CBC:

  WBCs: 6.7

  HGb:5.7

  MCV:87

  PLT:179

Ultrasonography

- Average size coarse liver
- Moderate enlarged spleen
- Marked ascites

The physician put LCF as the most probable diagnosis

He refered her to kafr-Elsheikh hospital at which recieved 4 units of blood transfusion for Anameia

With persistent complaints of fever and abdominal pain the patient was transferred to Mansoura universty hospital and admitted to the hepatology department as SBP.

On admission

The patient showed

fever (38.2)
Pallor
Thick scaly skin
Generalized abdominal tenderness
Moderate splenomgaly
Marked ascites
No jaundice
No oedema l.l.
No palbable L.NS

The following lab was done:

- S.alb:3.3
- Bilirubin:.0.8
- SGPT:18
- SGOT:23
- S.CREAT: 0.8
- HGB:7.6
- MCV:81
- INR:1.1
- URINE ANALYSIS: ALBUMIN ++

ULTRASONOGRAPHY:

- Average size liver
- moderate enlarged spleen
- Marked ascites
- Mild bilateral pleural effusion

Would you like to add further investigations?

The diagnosis of LCF was questioned and the following lab was done

- ESR:130
- 24hrs urinary protein: 1.5 gm/day.
- Reticulocytic count :2.5%
- Direct coombs test : +VE
- ANA:+VE (6 folds).
- ANTI-dsDNA: -VE

- Chest x-ray: bilateral mild pleural effusion mainly on left size

- ECHO: mild pericardial effusion

  No other significant abnormailties

ON THE BASIS OF:

- AUTOIMMUNE HAEMOLYTIC ANAEMIA
- PLEUROPERICARDIAL EFFUSION
- PROTEINURIA (1.5 GM/DAY)
- +ve ANA

The diagnosis of SLE was highly suggested.

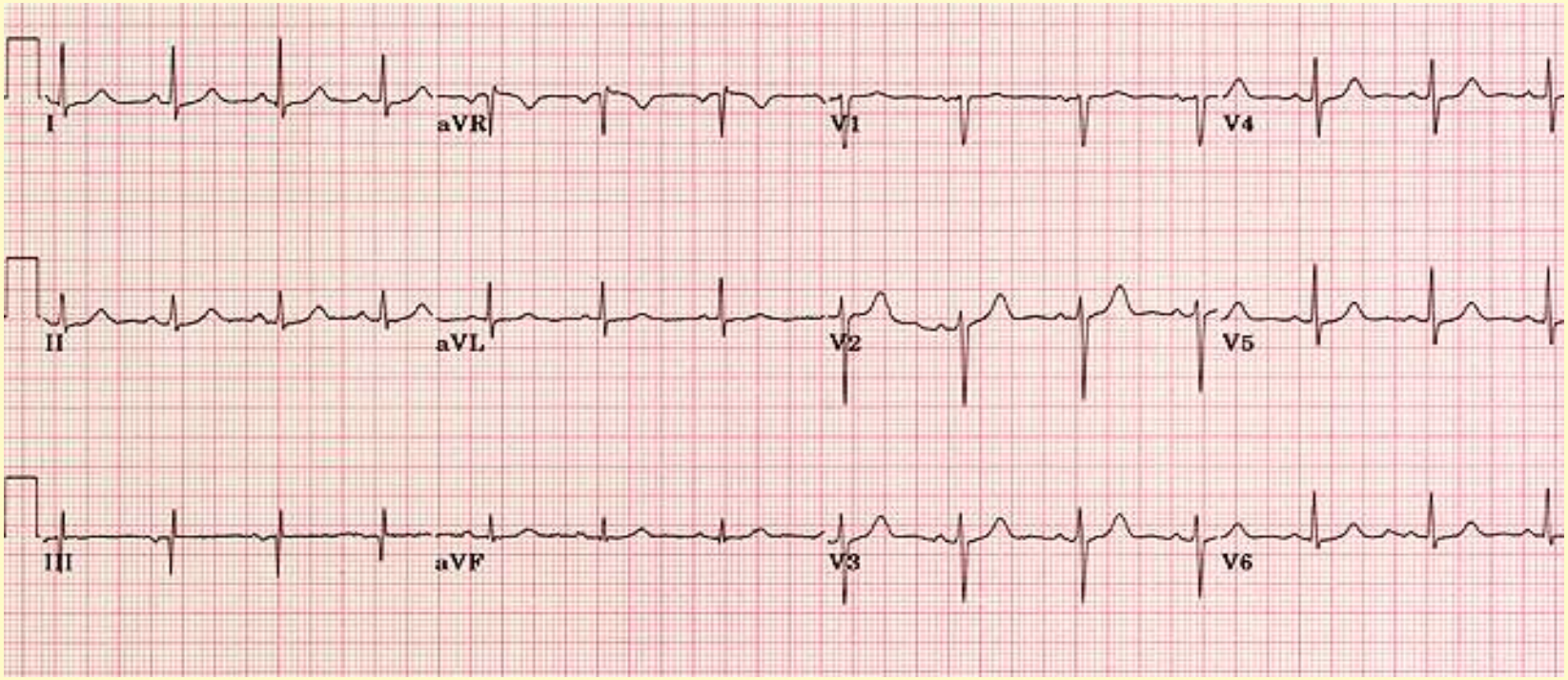
The patient started on high dose steroids

Broad spectrum antibiotic

But clinically the patient experienced Difficulty of breathing and chest pain .The pain is classically sharp and worsens when taking a deep breath

ABG:normal

ECG : showed no abnormalities



- However pulmonary embolism was suspected and CT-chest with contrast & D-DIMER were requested by chest consultants

- D-DIMER :+ve (30 folds).
- CT-chest &abdomen:

  para-aortic & mediastinal L.N.s

  Irregular ill defined splenic focal leisons for FNAC

  No evidence of pulmonary embolism

Few days later the patient started to develop generalized lymphadenopathy (Inguinal, Axillary and cervical L.Ns),

firm in consistency,freely mobile with variable sizes ranging from few mms up to 3*3 cm in inguinal region.

FOLLOW UP LAB

- ESR: 110
- ANA: +VE (2 FOLDS).
- ANTI-ds DNA : -Ve
- HGB: 8.3MCV:79
- 24 HR Urinary protein: 750 mg/day
- S.creat: 4

TWO SCENARIOS ARE SUGGESTED

Contrast nephropathy

Lupus nephritis

RENAL BIOPSY IS RECOMMENDED

but two obstacles are against:

Marked ascites

INR:1.5

so pulse steroid was started on the basis of lupus nephritis (1gm solu-medrol for 3 days)

The patient didnt improve ,became more oliguric even anuric and s.creat continued to rise

4 → 10 and dialysis was started

The descion of adding more immunosuppressives was not supported because again

LUPUS NEPHRITIS OR NOT WAS A BIG QUESTION

The lab results were

- ESR:97
- ANTI-dsDNA :-VE
- C3&C4: N
- URINE ANALYSIS:

PROTEINURIA :+

RBCs:1-3/HPF

pus cells:3-5 /HPF

ASCITIC FLUID ANALYSIS: wbcs:100

HOW WOULD YOU FURTHER PROCEED?

- The patient maintaned on 60 mg steroid and programmed haemodialysis

RENAL BIOPSY STILL CONSIDERED &THE PATIENT IS STILL UNFIT

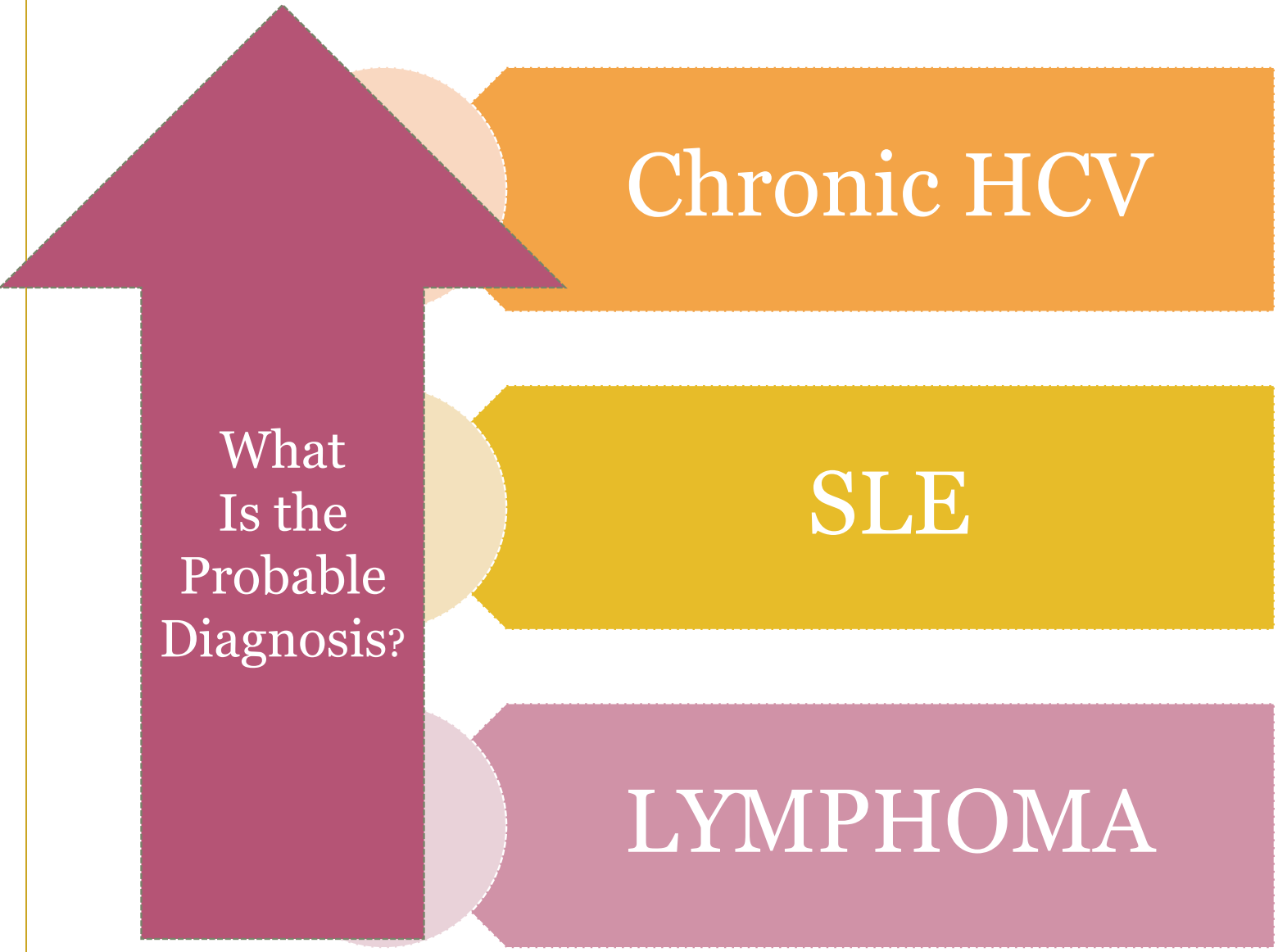
Lymph node Biopsy was taken and sent for Histopathological evaluation

we had a high suspicion of lymphoma

We are confronted with

- generalized lymphadenopathy some have distorted shape&hilum by u/s.
- Irregular ill defined splenic focal leisons
- Rapidly accumulating ascites
- Very high ESR

IT seems more explaning of other clinical findings


What Is the Probable Diagnosis?
Chronic HCV
SLE
LYMPHOMA

REACTIVE L.NS

NO EVIDENCE OF LYMPHOMA

HOW WOULD YOU PROCEED?

2 WEEKS AFTER

- THE PATIENT IS STILL ON DIALYSIS and HIGH DOSE STEROID
- FNAC was not supported by radiologists and instead suggested open splenectomy which was also not supported by surgeons and still renal biopsy not available

ANOTHER MORE SIGNIFICANT L.N WAS SENT FOR RE-PATHOLOGY

LYMPHOPROLIFERATIVE DISORDER MOSTLY

ANGIOIMMUNOBLASTIC LYMPHOMA

THE PATIENT WAS TRANSFERED TO THE ONCOLOGY DEPARTMENT WHERE SHE DEVELOPED GENERALIZED CONVULSIONS PASSED IN DEEP COMA AND ADMITTED TO ICU

CT-brain was done and showed no abnormalities

During which the renal condition started to improve,UOP increased and s.creat gradually declined to normal

The patient recieved non specific ttt during

her ICU stay in the form of

iv epanutin

dexamethasone

antibiotics

and completely improved with consciousness regained to normal and fits were controlled

BUT ANOTHER DISAPPOINTING SURPRISE

THE IMMUNOSTAINING FOR CD 3 &CD20 and staining by CD 10 REVISION FOR HISTOPATHOLOGY WERE ALL NEGATIVE

REACTIVE LYMPH NODES

BMA was also normal

THE PATENT AGAIN IN OUR DEPARTMENT AS LYMPHOMA IS EXCLUDED

The patient now has

- Marked HSM
- Marked ascites
- Generalized lymphadenopathy
- Mulitple skin leisons on the abdomen and upper thighs (irregular flat leisons ,dark brownish in colour)

The most obvious is psychatric behaviour,irritability all the time,always crying and shouting exposing herself claiming that her skin leisons are so painful

Dermatological consultation for skin leisons suggested self inflicted leisons

So is this psychatric behaviour can be accepted in this socially deprived young widow that through along hospital stay of about three months no one visited her and no relatives are caring or psychatric manifestations may be expressing lupus cerebritis

Social deprivation?

Lupus cerebritis ?

HOW WOULD YOU PROCEED?

THE FOLLOWING INV WERE DONE (1/7/2012)

- ANA : +VE (1.39) positive>1.1
- ANTI-dsDNA : -VE
- ANTI-SMITH Ab :- VE
- S.CREAT: 0.8
- S.CA :7.9
- S.Phosphrus: 4.4
- ESR :95
- C3: 0.85 (N :0.9-2.0)
- C4: N

TO BE CONTINUED.....

- S.URIC ACID :8.1
- LDH :436
- INR: 1.3
- CHEST X-RAY :Blunting of left costophrenic angle
- BONE SURVEY :N

THE PATIENT WAS CILINICALLY IMPROVING AS REGARD RENAL CONDITION ,NEUROLOGICAL ILLNESS, PERITONWAL INFECTION BUT MORE PSYCHOLOGICALLY DETERIORATING


Sudden death


Very disappointing end but we are waiting for your valuable ideas and analytical comments


THANK YOU